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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ______________________________________ **Date of Birth:** ______________________

I, hereby, authorize the communication of clinical information between:

____
(Name of Psychologist/Psychiatrist/Therapist)

of Reynolds & Rubino Psychology Group and the following individual and/or organization:

____
(Name of Person or Organization)

Address: ____

____

Phone: ____

Fax: ____

Communication is for the purpose of ☐ *coordination of care* ☐ *Other* *(be as specific as possible):* ___________

____.

Communication may include direct verbal communication, clinical documentation including inpatient and outpatient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that I may withdraw this consent at any time by submitting a request in writing. Please note that once the requested information is disclosed pursuant to this Authorization, Reynolds & Rubino Psychology Group will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

____ ____
Signature of Client or Legal Representative Date Signed

____ ____
Print Client Name or Legal Representative Relationship to Client

** This authorization for release of information is good for one year after date signed, until client revokes authorization, or until client is discharged from treatment (whichever precedes).